Intensive Behavioral Residential Services (IBRS)
Service Definition
DRAFT

Program Model

The Intensive Behavioral Residential Service is a clinical treatment model designed to meet the specific needs of each person supported by the program. The target population for this program is adults with intellectual disabilities who have exhibited high risk behavior, placing themselves and or others in danger of harm. This program is designed to be flexible enough to respond to the changing levels of need (LON) of the person supported and the level of risk (or lack thereof) presented by the person's current behavior. It is not an indefinite, long term, residential support service. A person with high risk behavior who is involved in this program will have opportunities to develop a lifestyle which includes developing healthy and meaningful relationships with others.

Program leadership is provided by the agency Clinical Director, who is responsible for ensuring service quality and providing clinical oversight of clinical and direct support staff. Administrative functions are performed by members of the management team.

1. Providers are licensed and operated as a mental retardation (i.e. Intellectual Disability) Residential Habilitation Facility.

2. Each residence is no larger than a four-person home.

3. Each home may have at least one safe area that provides a room or space to which a person may retreat in order to prevent or manage an escalating behavior.

4. The service:

    a. Includes an individual treatment plan which describes ongoing assessment and monitoring of the person supported and professional judgment regarding behavioral supervision, individual crisis plans, treatment objectives, and treatment planning.

    b. Allows for persons supported to learn and complete activities of daily living necessary for successful social integration.

    c. Has staffing ratios that are designed to be flexible in order to meet the need of people as events occur.

    d. Coordinates ancillary services that are flexible and responsive to the needs of the people supported. Ancillary services may be funded through the Managed Care Organization or the Medicaid Waiver; will vary according to the person's individual needs; and may include services such as counseling, psychotherapy, psychiatric consultation, medical, dental, and nursing and therapy services.

    e. Provides behavior analyst services that are embedded within the service and are flexible and available as needed within a 24 hour period.

    f. Ensures that Human Rights Committee and Behavior Support Committee approval is obtained prior to implementation of restrictive interventions, as necessary.

5. On-going safety and supervision may include:

    a. An intensive person-centered planning approach including determining what is important to and for the person and supporting him/her to achieve those goals identified in this process..

b. A carefully structured environment and a highly structured schedule with pre-planned activities, which the person supported participates in choosing and scheduling.

c. Proactive behavioral intervention approaches and teaching alternative strategies.

d. Learning healthy methods of expression.

e. Remote monitoring in public areas of the home.

f. Alarms to notify staff of elopement.

g. Windows designed for safety.

h. Other measures as recommended and approved.

6. Daily activities may include but are not limited to the following:

a. Supported employment when appropriate.

b. The training of self-management.

c. Training in essential life skills to attain or maintain integration in the community.

d. Habilitation, based upon individual needs and program strategies, to teach tasks that will assist the person in getting ready for a typical workday (e.g., making lunch, using public transportation, etc.)

e. Community exploration and integration.

Target Population and Behaviors

This program is designed for adults with intellectual disabilities who exhibit high risk behaviors that are dangerous or whose behaviors are so serious that when they occur, they present a potential danger to the person, staff, or the community.

Examples of the behaviors that meet criteria are behaviors that have caused harm in the past (e.g., sexual predatory behavior) and have a probability of reoccurrence. These behaviors can be reasonably expected to occur in the absence of a highly structured therapeutic environment without support, supervision, and training in alternative behaviors. Specific examples include the following:

1. Directly causes serious injury of such intensity as to be life threatening or demonstrates the propensity to cause serious injury to self, others, or animals.

2. Sexually offensive behaviors with high frequency of occurrence or sexual behavior with any person who did not consent or is unable to consent to such behavior, or engaging in public displays of sexual behavior.

3. Criminal behavior.

4. Cause serious property destruction (e.g., fire setting).

Clinical Director Qualifications

The Clinical Director is a knowledgeable, competent, and experienced professional with expertise in working with individuals with intellectual disabilities and intensive behavior support needs. The DIDD Director of Behavioral and Psychological Services and or designee shall verify the Clinical Director's qualifications.

Qualifications include the following:

1. Board Certified Behavior Analyst or Licensed Psychologist or Senior Psychological Examiner.

2. Minimum of three (3) years of experience, post licensure or certification, delivering services to people with dual diagnosis and high risk behaviors, and a Minimum of three (3) years of experience managing and supervising clinical and direct support professionals.

The Clinical Director's responsibilities include the following:

1. Participates in a statewide network to discuss current issues and best practices.

2. Engages in pre-planning activities with mental health, mobile crisis services, and local law enforcement to prepare for crisis situations.

3. Develops individual treatment plans.

4. Evaluates treatment outcomes.

5. Assists in transitioning persons supported from the program to other services and supports.

6. Supervises clinical staff.

7. Facilitates interdisciplinary treatment planning for all persons supported.

8. Implements program of ongoing staff development and training.

9. Ensures integration of and information sharing about ancillary services under the treatment plan, coordination with care managers representing the Medicaid state plan, and independent support coordinators regarding waiver services.

10. Provides orientation to ancillary service providers, physicians, and psychiatrists.

Direct Support Staff Training and Development

Direct Support Professionals involved in supporting program participants (e.g., assistance with meal preparation, attending appointments, and other activities of daily living) will participate in a rigorous program of staff training and development which is in addition to training currently required for all DSS (e.g., CPR, fraud and abuse reporting). The training program may include but is not limited to the following:

1. Training Specific to the person supported (e.g., recognition of each person's behavioral phases and appropriate responses and interventions for each phase and each person's unique mental and behavioral health challenges).

a. Understanding of the complexity of individuals with high risk behavior.
b. Understanding of the psychological and physical stressors on people supported.
c. Strategies needed to anticipate and alleviate potential crisis situations.
d. Practice in the use of incidental training.

2. Professional coping mechanisms to alleviate stress and prevent burnout.

3. Person-centered planning and philosophy of service delivery.

4. Forming and managing relationships with individuals with complex behavioral and emotional issues including maintenance of personal and professional boundaries.

5. Crisis management including how to carry out emergency manual restraint, emergency mechanical restraint, and the use of emergency protective equipment for persons supported. Training may include the following topics:

   a. Crisis prevention and management
   b. Proactive measures to avoid confrontation
   c. De-escalation of a situation
   d. Implementation of a crisis plan
   e. Protection during physical confrontations
   f. Use of staff personal protective equipment

6. How to work with other professionals such as psychiatrists and other clinical disciplines.

7. Working with the police and mobile crisis when a high risk situation occurs.

8. Applicable standards of the Occupational Health and Safety Administration (OSHA).

9. How to conduct environmental sweeps for high risk items.

10. Foundations of mental health, mental illness, general health and how they relate to behavior.

11. Healthy relationships.

Management Staff Training and Development

The program manager(s) is responsible for overseeing daily management activities to ensure that the program operates smoothly. Specific tasks may include development of policies and procedures, evaluating direct support staff, and monitoring compliance with DIDD quality standards. Managers will receive the same training as direct support professionals and additional training in:

1. Conflict management.

2. Supervision of staff.

3. Matching staff to the situation.

4. Working across agencies.

5. Recognizing and responding to stress.

6. Measuring quality and continuous improvements.

7. Mentoring.

Admission Review Process

The Admissions/Discharge Committee is responsible for reviewing and approving each person who is referred to the program. Referrals will be generated from persons supported who have been served at the highest level of need (LON) in terms of intensity, supports, and services yet have not received any benefit or minimal benefit from services at said level. Referrals may also be generated for persons entering the system who have issues identified that are consistent with those noted for the target population.

The Admissions/Discharge Committee will review referrals from state case managers, independent support coordinators, and DIDD providers.

The Admissions/Discharge Committee is comprised of the Director of Psychological and Behavioral Services (Chair), selected clinicians, and central/regional office staff. For each person referred to the program, the committee will review the following information: intake plan, independent support plan (ISP), risk assessment, clinical assessments, and health evaluations.

Continued Stay/Discharge Criteria

1. Continued placement in the program requires periodic (at least every three months) evaluation by the Clinical Director of the continued likelihood of occurrence of presenting behaviors and progress/benefit in continuing the program. The Clinical Director shall submit recommendations regarding continued stay or discharge to the Admissions/Discharge Committee, who shall make the final determination.

2. An individual shall be considered for discharge if the individual has met the clinical objectives identified in the clinical plan or the individual/legal representative has refused to participate in treatment.

Provider Qualifications and Requirements

Agency providers seeking to deliver this service will be reviewed by the department's Provider Development Committee. This committee will review the provider's qualifications and performance history to determine eligibility to contract with the department and the Medicaid agency to deliver this service. Final determination will be made by the DIDD Director of Behavioral and Psychological Services or designee.

Providers are required to submit a program proposal that incorporates the following:

1. Evidence of eligibility for licensure or licensure as a residential habilitation facility.

2. Experience delivering specialized services for people with intellectual disabilities and high risk behaviors.

3. Resumes or vitas for local clinical and administrative leadership (e.g., Clinical Director, management staff).

4. Plan for training direct support professionals and management, including refresher training for maintenance of skills.

5. A description of the treatment milieu and interventions designed to enable persons supported to build social and interpersonal skills, as well as regulate or extinguish problem behaviors. Examples include the following:

a. Methods for building social and vocational competence.
b. Measures to promote the safety and well-being of the person supported, staff and the community.
c. Procedures for contacting law enforcement and/or mobile crisis.
d. Method for evaluating the need for ongoing intensive behavior services at least every three months.
e. A system for providing transition services if a person transitions to an alternate setting.

Funding

The rate is $466.55 per day per person supported. This is a 24-hour rate that includes behavior analyst services. The rate assumes that 3 or 4 persons supported reside in the home. Ancillary services, including therapies (e.g., OT, PT, and Speech), psychotherapy and psychiatric consultation are to be provided as needed through Medicaid state plan services, Medicare, and or the Medicaid Waiver.